DEPARTMENT OF THE ARMY
WALTER REED ARMY MEDICAL CENTER
6900 Georgia Avenue, N.W.
Washington, DC 20307-5001

WRAMC Regulation
No. 40-108

8 July 2002

Medical Services

UTILIZATION MANAGEMENT PROGRAM

1. History. This regulation is the first issue of the Utilization Management Program.

2. Purpose. This regulation outlines function of the Utilization Management Program within the organization. It looks at cost efficiency, length of stay, access to care and the review that is done to ensure the quality and timeliness of the care rendered.

3. References.

a. DOD Policy Directive, Department of Defense Utilization Management Policy for the Direct Care System, HA Policy 98-031, 15 Apr 98.

b. DOD Population Health Improvement Plan and Guide, December 2001.

c. Joint Commision on the Accreditation of Healthcare Organizations, Comprehensive Accreditation Manual for Hospitals.

d. TRICARE Website: www.tricare.osd.mil.

e. AR 40-68, Quality Assurance Administrative Guide, 20 Dec 89.

f. TRICARE Northeast Administrative Guide, 3rd Edition, Sierra Military Health Services, Inc.

g. WRAMC Reg 40-614, Interdisciplinary Discharge Planning Program, 3 Jul 02.

h. InterQual® Level of Care Criteria, 2002.

4. Definitions.

a. Absent Sick Review – A review done on any active duty service member who is absent from military duty due to confinement in a medical facility other than their site of enrollment for health care. The WRAMC UM program tracks Army soldiers who are enrolled to any of the Walter Reed Health Care System (WRHCS) primary care enrollment sites in the Absent Sick Review.

b. Beneficiary – An individual entitled to health care benefits. are enrolled to any of the Walter Reed Health Care System (WRHCS) primary care enrollment sites in the Absent Sick Review.

c. Concurrent Review – A review that focuses on the ongoing care of a particular patient to ensure the appropriate use of resources while that patient is still receiving care.

d. Retrospective Review – An assessment of care conducted after an episode of care (e.g. an admission) is concluded that focuses on the appropriate use of health care resources.

e. Utilization Review – An assessment of the medical appropriateness of the course of treatment for a particular patient. Utilization Reviews may be done prospectively, concurrently, and/or retrospectively. Utilization Reviews may also be done to assess the medical appropriateness of health care processes.

f. First Level Review – An initial screening utilization review process used to verify the medical appropriateness of care based on defined medical criteria. These screens may be done once or may be repeated throughout an episode of care. At Walter Reed, UM nurses review inpatient care based on InterQual criteria. First Level Reviews are also done by our Managed Care Contractor when they receive a request for civilian care for a TRICARE beneficiary. Those reviews verify beneficiary eligibility for care, verify health plan coverage for the proposed care, and check whether the provided justification for care meets defined criteria.

g. Second Level Review – Reviews done by one or more clinicians when the initial screening utilization review process (1st level review) raises questions as to the medical appropriateness of care. At Walter Reed these reviews for clinical appropriateness are done by either the clinical department/service chief or his/her designee. For cases within the review purview of the managed care contractor, one of a cadre of staff physician is assigned to do these reviews.

h. Third Level Review – These reviews are done by the hospital Commander in cases where the clinical second level reviewer concludes that the care a patient or provider is seeking is not medically necessary or appropriate. These reviews are generally done at the request of a beneficiary.

i. Variance – Any activity, (procedure, treatment, test, or outcome) that unexpectedly alters the anticipated discharge of a patient.

j. Utilization Management – A set of techniques used to evaluate and influence health care delivery decisions by either making case-by-case assessments of the appropriateness of care or through the evaluation of health care system processes.

k. InterQual® Level of Care Criteria – A complete utilization review tool that enables the user to identify: Clinical parameters (Severity of illness) requiring admission to a given level of care. Therapeutic interventions (Intensity of Service) requiring admission and continued stay. Discharge readiness as determined by the application of Discharge Screens.

5. Responsibilities.

a. Deputy Commander for Clinical Services is responsible for the Utilization Management(UM) Program at Walter Reed Army Medical Center(WRAMC).

b. Chief, Utilization Management

(1) Plans, organizes and evaluates the following functions as performed or monitored by the UM staff.

(a) Conducts initial screens for appropiateness of care and setting of care through the use of prospective, admission, concurrent and retrospective reviews in accordance with the most current version of the InterQual® Level of Care Criteria. Further chart review and discussion with clinical staff for cases not meeting InterQual® criteria will be conducted as indicated.

(b) Reviews and monitors records of inpatients with an extended length of stay (LOS) including 100% review of both the records of medical inpatients with LOS over 10 days and the records of psychiatry inpatients with LOS over 20 days.

(c) Reviews and monitors the records of those inpatients identified as requiring a medical evaluation board to ensure that they are initiated in a timely manner.

(d) Identifies, reviews and tracks the records of civilian emergencies and incapacitated Reserve Component (RC) personnel to ensure that resources are allocated to those individuals eligible for care at WRAMC.

(e) Coordinates transfers to the appropriate setting and level of care in concert with the appropriate MTF providers and works to ensure timely processing, treatment and discharge.

(f) Develops, collects, trends and assesses outcome measures, such as readmission rates, bed day rates and LOS.

(2) Provides regular briefings to the Commander on UM issues and activities.

(3) Facilitates timely interaction between appropriate staff members, sharing significant UM findings, issues, problems or problem resolutions to department chiefs and members of the multidisciplinary teams.

(4) Provides inservice education and advice on UM topics to the command, clinical departments, UM/PI teams and other individuals as requested.

(5) Serves as a member of the hospital Quality Outcomes Committee.

(6) Facilitates all requests for third level reviews for the TRICARE Program.

6. GOALS AND OBJECTIVES.

a. To ensure that all health care services rendered are cost effective, delivered in the most appropriate setting, and optimized for both the quality and timeliness of the care rendered.

b. To collect data that assist both clinicians and administrators in the care delivery process.

c. To optimize Defense Health Plan expenditures with business decisions based on Utilization Management/Process Improvement (UM/PI).

d. To facilitate partnering with the Managed Care Support Contractors where advisable while sustaining high quality care and outstanding patient satisfaction.

7. INPATIENT REVIEW CRITERIA.

a. **FIRST LEVEL REVIEW.** InterQual® Level of Care components, Severity of Illness (SI), Intensity of Service (IS), and Discharge Screens (DS) will be used as the first level of review for all medical, surgical, acute rehabilitation and pediatric admissions. Admission and current review will be conducted within 24 hours or the next business day after the admission to verify the appropriateness and medical necessity of the hospitalization. Concurrent review will be conducted at least every 5 days throughout the hospital stay. During the admission and concurrent review process the nurse reviewer will cite any variance, i.e. any activity (treatment, procedure, test, or outcome), which seems to have altered the anticipated discharge date, the expected cost, or the expected outcome. Variances may fall into the following four categories:

(1) Operational variance occurs whenever the resources needed to meet standards of care are not available in a timely manner.

(2) Healthcare provider variance occurs whenever the actions of a healthcare team member appears to unnecessarily cause a delay in achieving the expected outcome and disposition timeline.

(3) Patient related variance occurs whenever the patient or family member appears to be responsible for the delay in outcome and disposition timeline.

(4) Unmet clinical outcome variance occurs whenever the intermediate and/or target discharge outcomes cited in the standard are not met and variances due to unmet resource needs, provider decisions, or patient actions are not apparent.

b. **SECOND LEVEL REVIEW**. Cases which upon review by the UM staff do not meet medical necessity criteria will be forwarded for review to selected physicians in the same clinical area. The second level physician reviewing the case will be the department or service chief or his/her designee and will not be directly involved in the care of the case in question. If the admission is found to be inappropriate by medical criteria and a militarily unique situation is not present, the clinical staff is asked to expedite the discharge or transfer of the patient. When the reviewing physician and the clinical staff caring for the patient disagrees, the case is presented to the Deputy Commander for Clinical Services for a final decision.

8. REVIEW CRITERIA FOR REQUESTS FOR CIVILIAN CARE

a. **FIRST LEVEL REVIEW.** When a TRICARE Prime beneficiary requests a consult for outpatient care or services to be provided by a civilian provider, network or non-network, the first level review is done by our managed care contractor who reviews the requested care for medical appropriateness and necessity and also for benefit coverage under the TRICARE Prime health plan. Cases that are not approved on first level review are automatically sent to second level review.

b. **SECOND LEVEL REVIEW**. Requests for outpatient care/services to be provided by a civilian provider that are denied by the managed care contractor are forwarded through the Chief, UM to the responsible clinical department or service for clinical review. The second level physician reviewing the case will be the department or service chief or his/her designee and will not be directly involved in the care of the case in question. Requests for the Program for Persons with Disabilities (PFPWD) undergo both first and second level review with the managed care contractor. If a request is denied at second level review, beneficiaries will all be informed that they may request a third level review by the hospital commander.

c. **THIRD LEVEL REVIEW**. Third level reviews are done at the request of a beneficiary, and will be forwarded through the Chief, Department Health Plan Management to the Hospital Commander for review and final decision.

9. OTHER REVIEWS.

a. Retrospective Review may be conducted after discharge to determine trends or patterns in over-utilization, under-utilization and misutilization of resources and as a performance measure of the UM process. Additionally, these reviews may be used to identify quality of care issues or to document that standards of care are met or exceeded.

b. Absent Sick Reviews will be conducted on any active duty service member who is absent from duty due to confinement in a hospital other then Walter Reed Army Medical Center. Admission and concurrent review will be performed on these patients within 24 hours of notification that a beneficiary is confined in a civilian hospital. These reviews will be conducted in the same manner as those conducted for inpatients at WRAMC.

10. CASE MANAGEMENT. Referrals for case management will be made to the Chief, Care Continuum Management Service. The following flags help to identify patients who might be candidates for case management.

a. Identified by High Risk Screen (see discharge planning).

(1) Extended hospital stay.

(2) Patients from out of catchment area (e.g., Air Evacuation cases).

(3) Patients with three or more admissions during the same year.

(4) Risk Management concerns.

b. Coordination with Lead Agent/Contractor Resources for Case Management. To ensure that Army resources and DoD Programs are fully utilized in the delivery of care management services, Walter Reed UM may coordinate case management services with the Lead Agent and or TRICARE contractor.

11. DISCHARGE PLANNING. The roles that UM staff plays in the discharge planning process are spelled out in the WRAMC Interdisciplinary Discharge Planning Program Regulation.

12. ANNUAL REVIEW. The Walter Reed UM Program, including this plan, will be reviewed and evaluated at least annually to reflect the changes in utilization review requirements.

13. CONFLICT OF INTEREST. A practitioner will not review the records of his patients for proper utilization of hospital resources.

14. CONFIDENTIALITY/DENIALS/APPEALS. Confidentiality, Denials, and Appeals will be handled in accordance with guidance in the DOD UM policy.

The proponent agency of this publication is the Directorate of Health Plan Management. Send comments and suggested Improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, Walter Reed Army Medical Center, ATTN: MCHL-DHPM-UM, 6900 Georgia Avenue, NW, Washington, DC 20307-5001.

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